CITY OF HAMPTON

MEDICARE SUPPLEMENT PLAN

EFFECTIVE JANUARY 1, 2011

BENEFIT SUMMARY

To receive the level of benefits outlined below, you must be enrolled in both Part A and Part B of Medicare.

MEDICARE PART A HOSPITAL SERVICES PER BENEFIT PERIOD*

BED PATIENT CARE	MEDICARE PAYS	PLAN PAYS	YOU PAY
Semi-private room and board, general nursing and misc. services and supplies			
First 60 days	All but $1,132 per benefit period	$1,132	$0
61st through 90th day	All but $283 per day	$283 per day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 per day	$566 per day	$0
Once lifetime reserve days are used -- additional 365 days	$0	100% of Medicare eligible days	$0
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entering a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $141.50 per day	Up to $141.50 per day	$0
101st day and after	$0	$0	All costs
Blood First three pints	$0	Three pints	$0
Additional amounts	80%	20%	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and	All but very limited coinsurance for out-	$0	Balance

you elect to receive these services	patient drugs and inpatient respite care

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

MEDICARE PART B MEDICAL SERVICES PER CALENDAR YEAR

MEDICAL EXPENSES	MEDICARE PAYS	PLAN PAYS	YOU PAY
In or out of the hospital and outpatient hospital treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $162 of Medicare-Approved Amounts** (Part B deductible)	$0	$162	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $162 of Medicare-Approved amounts	$0	$162	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	$0	$0
Annual wellness exam	100%	$0	$0
MEDICARE PARTS A AND B			
Home Health Care			
Medicare-Approved services: medically necessary skilled care, services and medical supplies	100%	$0	$0
Durable medical equipment, first $162 of Medicare-Approved amounts**	$0	$162	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

***Once you have been billed $162 of Medicare-Approved amounts for these covered services, your Part B deductible will have been met for the calendar year.*

AT-HOME RECOVERY SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
(Not covered by Medicare)			
Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Maximum allowed amounts up to $40 per visit	Balance
Number of visits covered (must be received within eight weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$1,600	

PRESCRIPTION DRUG BENEFITS PER CALENDAR YEAR**

Extended Outpatient Prescription Drugs

First $250 each calendar year	$0	$0	$250
Next $8,333 each calendar year	$0	60%	40%
Over $8,583 each calendar year	$0	$0	All costs

**Persons who are entitled to Medicare Part A or Part B became eligible for Medicare Part D prescription drug benefits on January 1, 2006, due to the enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003. If you are entitled to Medicare Part A or Part B, you may enroll in Part D as well; however, the prescription drug coverage included in this Medicare Supplement plan is intended instead of enollment in Part D. Your group health plan provides retiree prescription drug coverage that is equivalent to the benefits that would be provided under Medicare Part D. If this employer-provided retiree prescription drug coverage ends or changes so that it is not equivalent to Medicare Part D benefits later, those who were covered under it will still be able to enroll in Medicare Part D. No late-enrollment penalty will apply for those who enroll according to Medicare's rules and provide a "certificate of creditable coverage" showing that they have been covered by an equivalent employer-provided prescription drug plan. If you need a certificate of creditable coverage with which to later enroll yourself or you spouse or dependent in Medicare Part D, and have not already received it from your employer, please see your group administrator.

If you enroll in Medicare Part D, then this Medicare Supplement prescription drug benefit becomes secondary to the Part D benefit, and coordination of benefits will occur.

OTHER BENEFITS NOT COVERED BY MEDICARE

Foreign Travel *(not covered by Medicare)* Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% up to a lifetime max. of $50,000	20% plus amounts over $50,000 max.

	MEDICARE PAYS	PLAN PAYS	YOU PAY
Preventive Medical Care not covered by Medicare Check-ups, preventive tests and services such as: fecal occult blood tests, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

YOUR MEDICARE SUPPLEMENT PROGRAM

Your Medicare Supplement Program helps pay the bills Medicare does not pay. It works together with Medicare. For example, when Medicare pays 80% of an expense, Medicare Supplement plans pay the other 20% of the Medicare-approved charge. Medicare Supplement plans keep pace with Medicare changes. As deductibles, copayments and coinsurances increase, your Medicare Supplement insurance will expand accordingly to cover these increased amounts.

Your Medicare Supplement Program covers many types of services, including prescription drugs, at-home recovery care and Part B charges that are above Medicare's approved and covered amount.

ELIGIBILITY

Retirees/spouses who were enrolled in the City of Hampton group health insurance plan are eligible to enroll in the City of Hampton Medicare Supplement Program once they are eligible for Medicare.

Reminder: Once eligible for Medicare, retirees/spouses are no longer eligible for the City of Hampton group health insurance plan.

CLAIMS FILING PROCEDURES

When you receive covered services, give your hospital or doctor your Medicare number and your Blue Cross and Blue Shield identification number. The provider of services will usually bill Medicare and Anthem Blue Cross and Blue Shield. Payment will be made directly to the provider unless the bill shows you have already paid it.

If the doctor's office will not bill Anthem Blue Cross and Blue Shield or if you receive services for prescription drugs and insulin or other services not billed for by a doctor or hospital, you will have to file the claim yourself. To file a claim, follow these steps:

1. Wait until you have received your "Explanation of Medicare Benefits" in the mail if the services were received from a doctor.

2. Fill out a Anthem Blue Cross and Blue Shield claim form.

3. Attach the "Explanation of Medicare Benefits" (if applicable) and any itemized bills to the claim form, and mail them to Anthem Blue Cross and Blue Shield.

4. Anthem Blue Cross and Blue Shield will pay you directly.

DEFINITIONS

Medicare Allowed Amount

This is the amount that Medicare recognizes as reasonable for physician services covered by Part B. This amount is based on a national fee schedule and may be less than what doctors or suppliers actually charge for their services.

Medicare Deductible

The deductible is the amount you owe before Medicare begins paying for covered services and supplies. Both Part A and Part B of Medicare leave you responsible for deductibles, except where covered by this Supplemental Plan.

Medicare Coinsurance

After your Medicare Part B deductible is met, Medicare pays a percentage of the approved charge for services. The remaining amount, up to Medicare's approved amount, is referred to as coinsurance. This coinsurance is your responsibility, except where covered by this Supplemental Plan.

Copayment

This is a type of cost-sharing in which you pay a specified amount per service or per day, except where covered by this Supplemental Plan.

Part B Excess Charges

If a provider charges above Medicare's approved amount and does not accept the approved amount as payment in full, then you are responsible for the excess charges, except where covered by the Supplemental Plan.

CUSTOMER SERVICE

Anthem's customer service representatives will assist you with any questions you may have regarding your Medicare Supplement benefits. Call 1-800-451-1527 to speak to your Anthem representative.

WHAT IS NOT COVERED

Like all health care policies, our Medicare Supplement policies have exclusions. "Exclusions" are services not covered by your contract. When we say "services," we mean services and supplies. For more details please see your contract.

Benefits will not be provided for the following:

- Services you receive before the contract effective date.
- Services that are payable under Medicare.
- Services that are not Medicare eligible expenses except as stated in the contract.
- Services that are not reasonable by Medicare standards for diagnosis and treatment of certain conditions.
- Services in excess of Medicare's allowance for mental illness-related care.
- Free services, including services for which no charge would have been made if there was no insurance.
- Services from federal providers and federal agencies.
- Services paid (directly or indirectly) by a government entity.
- Services covered by workers' compensation or similar law, automobile or liability insurance plan, or employer group health plan required by law to pay benefits before Medicare pays benefits.
- Cosmetic surgery, including routine complications that result from the surgery except as required for repair of an accidental injury or to improve the function of a malformed body part.
- Dental care or treatment except as needed for treatment of accidental injury, removal of impacted wisdom teeth or medically diagnosed cleft lip, cleft palate or ectodermal dysplasia or dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- Certain foot care services, including flat foot condition treatment, orthopedic shoes, and other supportive devices for the feet.
- Services provided by relatives or by a household member.

- Personal comfort items.
- Eyeglasses, vision care, unless needed due to intraocular surgery.
- Hearing aids and examinations for these devices.
- Benefits for rest cures, custodial, residential, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.
- Benefits for care from institutions or facilities that are licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled, sub-acute inpatient settings.
- Services for an inpatient for conditions which require only observation, diagnostic examinations, or diagnostic laboratory testing.
- Inpatient services if the stay is mainly for physical therapy which could have been rendered on an outpatient basis.
- Services for an inpatient which might be safely and adequately rendered in a home, provider's office, or at any lesser level of institutional care.
- Any service determined to be experimental/investigative by the Company, in its sole discretion. Also excluded are services to treat routine complications of any experimental/investigative service.
- Any service determined to be not medically necessary by the Company, in its sole discretion (please see contract definition).
- Guest meals, telephones, televisions, and other convenience items.
- Services of any type rendered in conjunction with the services of an attending provider whose services are not covered by this contract.
- Local infiltration anesthesia.
- X-rays or other examinations for an inpatient which are not related to the diagnosis of the condition requiring that inpatient stay.
- Services for marital and family counseling, educational therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy.
- Scraping or removing corns or calluses and the trimming of nails.
- Covered facility services during a temporary absence from the covered facility.
- In vitro fertilization, ovum transplants and gamate intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures, including any drugs administered in connection with any type of artificial or surgical means of conception
- Services for acupuncture.
- Any services for treatment of the following conditions: anti-social personality, inadequate personality, sexual deviation, social maladjustment without apparent psychiatric disorder, group delinquent reaction of childhood, autistic disease of childhood, mental retardation, learning disabilities, and conduct and oppositional disorders.
- Services for occupational therapy or rehabilitative therapy if the primary purpose is to train the covered person for a new job.
- Separate charges by interns, residents, house physicians, or other health care professionals who are employed by the covered facility which makes their services available.
- Services for surgical sex transformation, including related medical services and psychiatric services.
- Services for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.
- Travel, even if prescribed by a provider.
- Services for routine or periodic physical examinations not related to a specific medical condition, school entry, work permit, insurance or employment exam in excess of the $120 annual maximum.
- Covered facility services for an inpatient only because environmental change is needed.
- Physical therapy to maintain motor functions, except when the Company determines there is a reasonable chance that the patient's motor functions will improve as a result of the therapy.
- Services for obesity or in connection with weight reduction or dietary control, whether or not a related medical condition exists. There is one exception. Covered facility's or provider's services to treat morbid obesity shall not be excluded.
- Nutrition counseling and related services, except when a part of a program of covered home health care services.

- Educational or teacher's services.
- Services which are not prescribed, performed, or directed by a provider licensed to do so.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual association, labor union, trust, or similar person or group.
- Services rendered after the date of termination of the covered person's coverage, except as provided in the General Provisions Section of the contract.
- Telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for giving information concerning a claim.
- Services to treat sexual dysfunction not related to organic disease.
- Services for radial keratotomy and other surgical procedures to correct nearsightedness and or farsightedness, including keratoplasty and Lasik procedure
- Services related to smoking cessation such as stop-smoking aids and the services of stop-smoking clinics.
- Reversals of sterilizations.
- Prescription drugs for: over-the-counter drugs, refills dispensed after one year from the date of the original prescription, contraceptive medications or devices unless prescribed for a purpose other than the prevention of pregnancy, weight loss, stop-smoking aids, or cosmetic purposes.
- High dose chemotherapy and/or high dose radiation, any supporting autologous, allogeneic or syngeneic bone marrow transplants or stem cell rescue and any medical problems that result from them
- Major organ and tissue transplants, and any medical complications from such services, except in limited circumstances as described in the group contract.
- Experimental or investigative procedures and complications except for clinical trials for cancer
- Services for learning disabilities or educational services except as specified in this book.
- Services for donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child or sibling).
- Benefits for services or supplies if they are deemed not medically necessary as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem's decision that a services is medically necessary.

  However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

  For inpatients

1. Services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. Services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

  For outpatients

  services of pathologists, radiologists and anesthesiologists.

LIMITATIONS

As with all health insurance policies, your Medicare Supplement contract has capped benefits. When we say "capped benefits" we mean certain benefits have dollar or visit limits on the total dollar amount or number of visits we will cover for a particular service. These limits are shown in the benefit chart in this brochure. Once you reach the dollar or visit limit on these benefits, the benefit ceases to exist as a covered service under this contract for the remainder of the benefit period.

This is not a contract. This is a summary of the benefits of the Anthem Blue Cross and Blue Shield Medicare Supplement program. Full information about benefits, exclusions and restrictions can be found in the City of Hampton Medicare Supplement Contract.